COORDINATING PEDIATRIC MEDICAL CARE ACROSS A COMMUNITY DURING AN INFLUENZA PANDEMIC

Clinician Outreach and Community Activity (COCA) Conference Call

September 22, 2010

Office of Public Health Preparedness and Response
Division of Emergency Operations

Objectives

At the conclusion of this hour, each participant should be able to:

- Discuss how primary care and multispecialty clinic can work collaboratively to manage pediatric emergencies during a wide spread H1N1 pandemic
- Describe steps which may be taken to promote infection control in an outpatient setting
- Identify elements that should be included in a healthcare facility's emergency plans to address a surge in pediatric patients

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TODAY'S PRESENTERS

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Pediatric Healthcare Response to Pandemic H1N1 Influenza

Sherline Lee, MPH

Division Of Healthcare Quality Promotion (DHQP)

The findings and conclusions in this presentation are those of the author and do not necessarily represent the views of the Centers for Disease Control and Prevention/the Agency for Toxic Substances and Disease Registry

CENTERS FOR DISEASE CONTROL & PREVENTION

Resources and Tools

- Planning Guide for Vaccinating Pediatric Patients Against 2009 H1N1 Influenza in Primary Healthcare Settings
- Health Care Providers and Facilities - Decision Tree for 2009 H1N1 Vaccination
- Pandemic Influenza Pediatric Office Plan Template
- Coordinating Pediatric Medical Care During an Influenza Pandemic: Hospital Workbook

Agenda

- Disaster Preparedness Initiatives
- Pediatric office response to 2009 H1N1
- Pediatric Surge and Hospital Readiness

American Academy of Pediatrics

Disaster Preparedness Initiatives

Sarita Chung, MD, FAAP
Disaster Preparedness Advisory Council

Division of Emergency Medicine
Children's Hospital Boston
Assistant Professor of Pediatrics
Harvard Medical School

DISCLOSURE STATEMENT

- Nothing to disclose.
- In the past 12 months, I have had no relevant financial relationships with the manufacturers of any commercial products or providers of commercial services discussed in this CME activity. I do not intend to discuss an unapproved/investigative use of a commercial product /device in my presentation.

Children, Pediatricians, and Disasters

Disaster Preparedness Advisory Council

(Initiated July 2007)

Council: *Primary Care, Mental Health, Infectious Disease, Emergency Medicine*

Liaisons: *DHS, CDC, FDA, NICHD, HHS ASPR*

Network:

50 pediatric disaster experts

600 members interested in disaster medicine

DPAC Activities/Accomplishments

- AAP Strategic Plan
- National Commission of Children and Disasters
- Advocacy and Policy Initiatives
- Appointments/Representation at Meetings
- Comments on Federal Proposals including the National Response Framework, National Recovery Framework
- Educational Presentations
- Pediatric Countermeasures Agenda
- Practice-based Resources
- Publications
- Testimony

AAP Activities: H1N1

- Quickly recognized as a pediatric pandemic
- Worked closely with CDC
  - To examine evidence and recommend to change guidelines
  - Identify children at high risk for severe illness
  - Influenza treatment algorithm for children
  - Practice guidelines for primary care offices and hospitals

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

2009-2010 Influenza Season Triage Algorithm for Children (18 years) With Influenza-Like Illness

This algorithm was developed for use only by physicians and those under their direct supervision, not for use by general public, to help in discussions and providing advice to parents or other caregivers of ill children regarding seeking medical care for an influenza-like illness. The algorithm can be used regardless of whether or not the child has been vaccinated for influenza. Caregivers of children who may have potentially life threatening signs and symptoms, such as unresponsiveness, or respiratory distress and/or cyanosis (blue-colored skin), should be instructed to dial 911.

If child < 2 years old are all of the following present?

1. Fever or feels feverish (if no thermometer available)*
2. Irritability or cough or vomiting/unable to keep fluids down

If child ≥ 2 years old are all of the following present?

1. Fever or feverishness*
2. Cough or sore throat

*If antipyretics are taken this may inhibit a patient's ability to mount a fever. If antipyretics have been taken, the patient can be reassessed 4 to 6 hours after acetaminophen or 6 to 8 hours after ibuprofen.

NO → Although some children with influenza may not exhibit the usual influenza symptoms including fever, this child's symptoms suggest that influenza is less likely. They do not meet criteria for this algorithm. The child should be assessed for alternative diagnoses.

YES

Is the child younger than 12 weeks old?

YES → Recommend immediate medical evaluation for child, preferably with child's medical home/ primary care provider, or refer for emergency medical care or 911 if any signs or symptoms of life threatening illness.

NO

Are any of the following signs or symptoms present?†

Age 12 weeks to <5 years

- Fast breathing‡ or difficulty breathing or retractions present
- Dehydration (no urine output in 8 hours, decreased tears or no tears when child is crying, or not drinking enough fluids)
- Severe or persistent vomiting/unable to keep fluids down
- Lethargy (excessive sleepiness, significant decrease in activity level, and/or diminished mental status)
- Irritability (cranky, restless, does not want to be held or wants to be held all the time)
- Flu-like symptoms improved but then returned or worsened within one to a few days
- Pain in chest or abdomen (for children who can reliably report)

Age 5 years

- Fast breathing‡ or difficulty breathing
- Dizziness or lightheadedness
- Severe or persistent vomiting/unable to keep fluids down
- Flu-like symptoms improved but then returned or worsened within one to a few days
- Pain in the chest or abdomen

YES → Recommend immediate medical evaluation for child, preferably with child's medical home/ primary care provider.

NO

Is the child at least 12 weeks old but less than 2 years old?

YES → This child falls into a group that may be at elevated risk for complications from influenza. Recommend that they be evaluated for possible treatment. Recommend that the child's caregiver contact the child's medical home/primary care provider that day.

NO

Does the ill child have any of the following conditions?

1. Neurological disorders such as:
   - Epilepsy
   - Cerebral palsy, especially when accompanied by neurodevelopmental disabilities (e.g., moderate to profound intellectual disability [mental retardation] or developmental delay)
   - Brain or spinal cord injuries
   - Neuromuscular disorders (e.g., muscular dystrophy), especially when associated with impairment in respiratory functioning
2. Chronic respiratory diseases such as:
   - Conditions associated with impaired pulmonary function and/or difficulty handling secretions
   - Technology dependent children (e.g., those requiring oxygen, tracheostomy, or a ventilator)
   - Asthma
3. Moderate to profound intellectual disability (mental retardation) or developmental delay, especially when associated with specific conditions (see #1, #2 above)
4. Deficiencies in immune function or conditions that require medications or treatments (e.g., certain cancer treatments, HIV infection) that result in significant immune deficiencies
5. Cardiovascular disease including congenital heart disease

YES → This child falls into a group that may be at elevated risk for complications from influenza. Recommend that they be evaluated for possible treatment. Recommend that the child's caregiver contact the child's medical home/primary care provider that day.

Disaster Preparedness for Pediatric Practices: An Online Tool

Disasters are unpredictable and can cause loss of life, destruction of property, and disruption of business operations. Pediatricians face special concerns including the inadequacy of disaster planning in addressing the needs of children (especially those with special needs), and the ongoing need to develop or improve their pediatric offices and personal disaster plans. A working plan can help practices reduce risks, maintain practice operations, and ensure a medical home for children in their care.

Develop your Disaster Plan Now

Instructions

Create a disaster preparedness plan for your medical home practice by answering questions in this interactive tool.

Choose a topic below:

- Practice Information
- Review Key Resources
- Plan for Continuing Operations
- Review Insurance Coverage
- Store Essential Supplies and Minimize Risk to Equipment
- Protect Patient Records and Office Files
- Handle Vaccine Issues
- Attend to Facility Issues
- Consider How to Handle Infection Control
- Prepare Office Staff/Employees
- Develop Service and/or Evacuation Plans
- Prepare an Office "Emergency Go Kit"
- Prepare a Plan for Communicating with Clients
- Develop a Preparedness Plan for Your Home and Family

Key Resources:

A Disaster Preparedness Plan for Pediatricians an article by Scott Needle, MD, FAAP that includes guidance and background information to help staff prepare the office in advance of a disaster.

The Role of Pediatric Health Care Providers an article by Daniel Fagbuyi, MD, FAAP and Jeffrey Upperman, MD, FAAP that offers steps pediatricians can take to promote pediatric emergency preparedness in the community (exiting site).

Supplemental Resources:

- AAP Children and Disasters Web Site
- AAP Health Topics Page on Disasters
- Continuity of Operations Plan
- Emergency Information Forms and Emergency Preparedness for Children With Special Health Care Needs
- Insurance Coverage for Vaccine Loss
- Pandemic Influenza Plan: Template for

Available at http://practice.aap.org/disasterpreptool.aspx

http://www.aap.org/disasters/index.cfm

Pediatric response to H1N1 2009

CentraCare Health System

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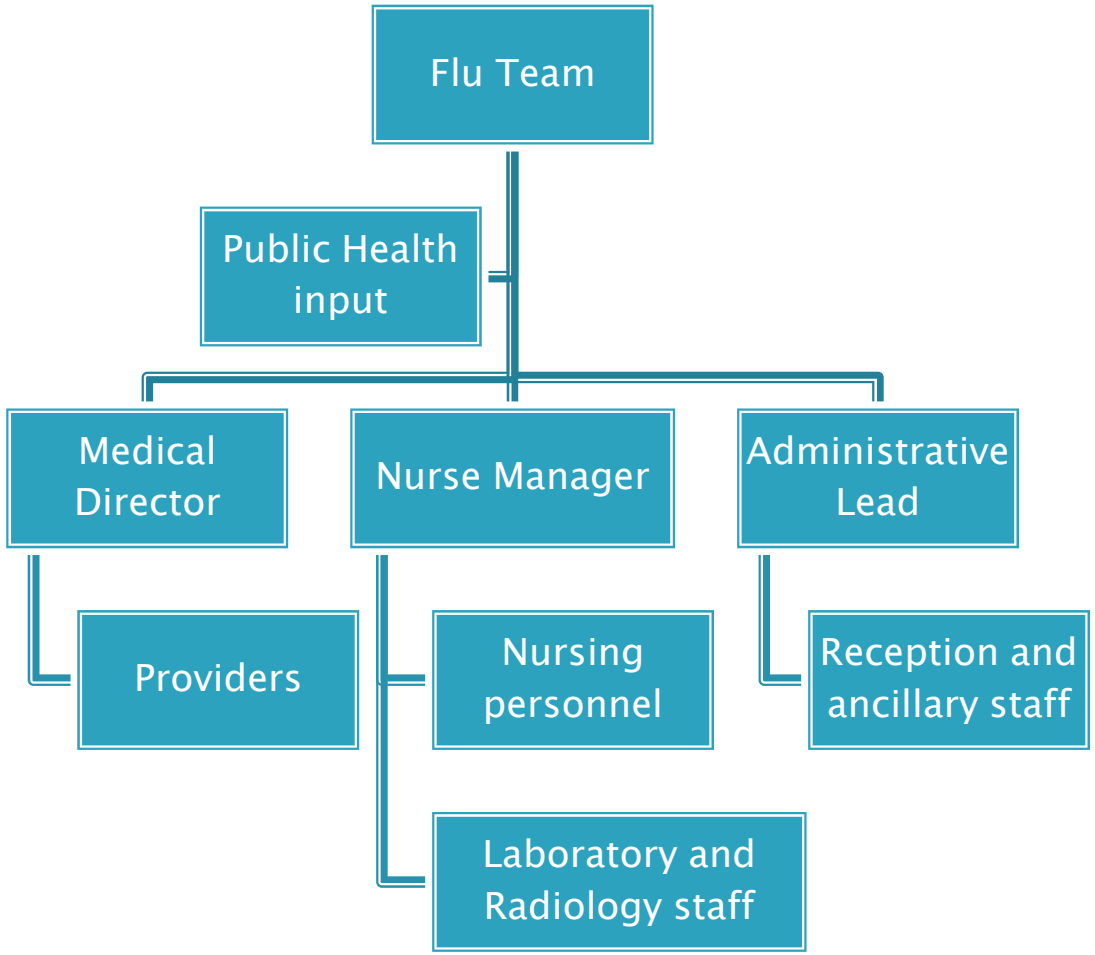
Ambulatory pediatric decision making structure

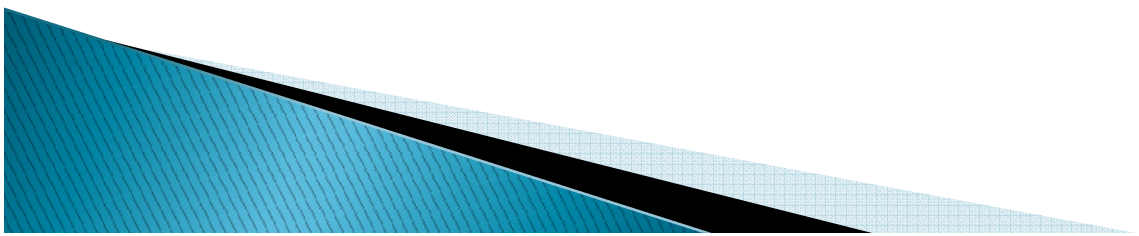


Flu Team Responsibilities

- Leadership
  - Decision making authority
  - Leading by example on the front lines
- Communication
  - Internal
    - Providers, nursing, other staff
  - External
    - Patients, public health contacts
- Development of policies and procedures
  - Segregation of patients
  - Staffing, exclusion from work

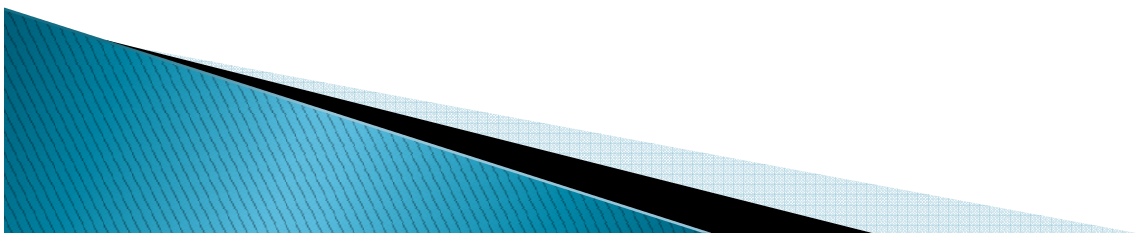
Communication

- Occurred through multiple modes:
  - Staff and patients
    - Website updates
    - Telephone messaging
    - Mass media
  - Staff alone
    - Email
    - Presentations/Q&A sessions
    - Daily briefings prior to work



Triage: Case Definitions

- Confirmed case: a person with an acute febrile illness with laboratory confirmation with one of the following tests:
  - RT-PCR
  - Viral culture
- Probable case: A person with an ILI(fever with cough or sore throat) who is positive for influenza A, negative for H1/H3 by PCR
- Suspect case (per MDH): a person with an ILI
- ILI: temp>100 plus cough or sore throat



Triage

American Academy of Pediatrics
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2009-2010 Influenza Season Triage Algorithm for Children (≤18 years) With Influenza-Like Illness

This algorithm was developed for use only by physicians and those under their direct supervision, not for use by general public, to help in discussions and providing advice to parents or other caregivers of ill children regarding seeking medical care for an influenza-like illness. The algorithm can be used regardless of whether or not the child has been vaccinated for influenza. Caregivers of children who may have potentially life threatening signs and symptoms, such as unresponsiveness, or respiratory distress and/or cyanosis (blue-colored skin), should be instructed to dial 911.

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If child ≥ 2 years old are all of the following present?
1. Fever or feverishness*
2. Cough or sore throat

*If antipyretics are taken this may inhibit a patient's ability to mount a fever. If antipyretics have been taken, the patient can be reassessed 4 to 6 hours after acetaminophen or 6 to 8 hours after ibuprofen.

NO → Although some children with influenza may not exhibit the usual influenza symptoms including fever, this child's symptoms suggest that influenza is less likely. They do not meet criteria for this algorithm. The child should be assessed for alternative diagnoses.

YES ↓

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NO ↓

Are any of the following signs or symptoms present?†

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- Severe or persistent vomiting/unable to keep fluids down
- Lethargy (excessive sleepiness, significant decrease in activity level, and/or diminished mental status)
- Irritability (cranky, restless, does not want to be held or wants to be held all the time)
- Flu-like symptoms improved but then returned or worsened within one to a few days
- Pain in chest or abdomen (for children who can reliably report)

Age ≥5 years
- Fast breathing‡ or difficulty breathing
- Dizziness or lightheadedness
- Severe or persistent vomiting/unable to keep fluids down
- Flu-like symptoms improved but then returned or worsened within one to a few days
- Pain in the chest or abdomen

YES → Recommend immediate medical evaluation for child, preferably with child's medical home/primary care provider.

NO ↓

Is the child at least 12 weeks old but less than 2 years old?

YES → This child falls into a group that may be at elevated risk for complications from influenza. Recommend that they be evaluated for possible treatment. Recommend that the child's caregiver contact the child's medical home/primary care provider that day.

NO ↓

Does the ill child have any of the following conditions?
1. Neurological disorders such as:
   - Epilepsy
   - Cerebral palsy, especially when accompanied by neurodevelopmental disabilities (e.g., moderate to profound intellectual disability [mental retardation] or developmental delay)
   - Brain or spinal cord injuries
   - Neuromuscular disorders (e.g., muscular dystrophy), especially when associated with impairment in respiratory functioning.
2. Chronic respiratory diseases such as:
   - Conditions associated with impaired pulmonary function and/or difficulty handling secretions
   - Technology dependent children (e.g., those requiring oxygen, tracheostomy, or a ventilator)
   - Asthma
3. Moderate to profound intellectual disability (mental retardation) or developmental delay, especially when associated with specific conditions (see #1, #2 above)
4. Deficiencies in immune function or conditions that require medications or treatments (e.g., certain cancer treatments, HIV infection) that result in significant immune deficiencies
5. Cardiovascular disease including congenital heart disease
6. Significant metabolic (e.g., mitochondrial) or endocrine disorders
7. Renal, hepatic, hematological (including sickle cell disease) disorders
8. Receiving chronic aspirin therapy
9. Pregnancy

YES → This child falls into a group that may be at elevated risk for complications from influenza. Recommend that they be evaluated for possible treatment. Recommend that the child's caregiver contact the child's medical home/primary care provider that day.

NO ↓

Is the child at least 2 years old but less than 5 years old?

YES → This child falls into a group that may be at elevated risk for complications from influenza. Recommend that the child's caregiver contact the child's medical home/primary care provider that day to discuss the need for further evaluation and treatment.

NO ↓

Child falls into a group that appears to be at lower risk for complications from influenza and may not require testing or treatment if their symptoms are mild. Should symptoms worsen (e.g., shortness of breath, unresolving fever) or should the child's caregiver have further questions or concerns about the child's health, recommend the caregiver contact the child's healthcare provider.

In order to help prevent spread of influenza to others, these patients should be advised to:
- Keep away from others to the extent possible, particularly those at higher risk for complications from influenza (see box below). This may include staying in a separate room with the door closed.
- Cover their coughs and sneezes
- Avoid sharing utensils
- Wash their hands frequently with soap and water or alcohol-based hand rubs
- Stay home (e.g., no school, child care, group activities) until 24 hours after their fever resolves without the use of antipyretics (i.e, acetaminophen, ibuprofen)

More information available at: http://www.cdc.gov/h1n1flu/guidance_homecare.htm

In addition, remember that vaccination for seasonal influenza and pandemic (H1N1) influenza is recommended for all children 6 months through 18 years old and household contacts and out of home caregivers of children less than 6 months old.

For all patients triaged using this algorithm the following should also be assessed:

Does patient live with a person at higher risk for complications of influenza including someone who is:
- Age <2 or age 65 or older, or
- Pregnant

Or someone with any of the following comorbid conditions:
- Chronic pulmonary disease (including asthma), cardiovascular (except isolated hypertension), renal, hepatic, hematological (including sickle cell disease), or metabolic disorders (including diabetes mellitus)
- Disorders that that can compromise respiratory function or the handling of respiratory secretions or that can increase the risk for aspiration (e.g., cognitive dysfunction, spinal cord injuries, seizure disorders, or other neuromuscular disorders)
- Immunosuppression, including that caused by medications or by HIV
- Child (≤18) on chronic aspirin therapy

YES → The higher risk contacts of these patients should be advised to contact their medical home/primary care provider that day for advice on steps they might need to take to prevent infection.

In addition, vaccination for seasonal influenza and pandemic (H1N1) influenza should be recommended for all children 6 months through 18 years old and household contacts and out of home caregivers of children less than 6 months old.

*These symptoms are purposely broad to minimize the possibility of misclassifying people who truly have severe symptoms. The person attempting to triage the patient should take into account the severity and duration of the symptoms when deciding whether or not patients should be advised to seek evaluation immediately

‡Suggested respiratory rates indicative of "fast breathing" included in Box 1 in Appendix

Appendix

Box 1: Definition of "Fast Breathing"

Age	Respiratory rate
Birth up to 3months	> 60/min
3 months up to 1 year	> 50/min
1 to < 3 years	> 40/min
3 to < 6 years	> 35/min
6 to <12 years	> 30/min
12 to 18 years	> 20/min

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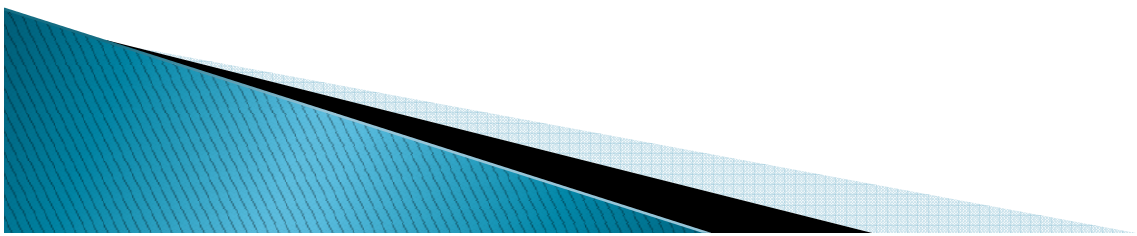
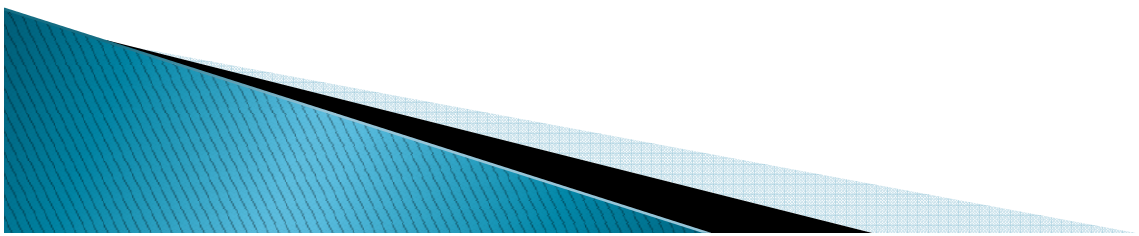
Triage Challenges

- Broad case definition
- Worried well
- Frequency of risk factors in the population, specifically asthma
- Lack of accurate rapid test
- Intermediate risk 2-5 age group



Staff Education

- Mandatory staff education sessions
  - Same educators for all sites
  - Same message (Clinic, Hosp, Region and State)
  - Jeopardy Power Point
  - Q & A Session
  - Correct usage of PPE (donning and doffing)
  - Daily Updates
  - See page # 7 (Pediatric Office Pandemic Plan template)



Patient Education

- Hand Washing (Signage in multiple languages)
- Proper use of wearing a mask
- Cover your cough
- See page # 10 (Pediatric Office Pandemic Plan template)

Infection Control Procedures/Patient flow

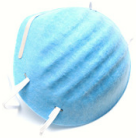
- Developed a Hot Zone
- Segregation of patients
  - Check in -Reception/Triage
  - Designated waiting areas ill/well
  - Patient masked and roomed immediately
  - Exam rooms-designated as Hot Zone rooms
  - Designated hallways
  - Equipment- Hot Zone only
  - Signage-(very important)
  - See pages 11-14 (Pediatric Office Pandemic Plan template)

Hot Zone Signage

GOWNS

ONLY!

For patient and staff protection,



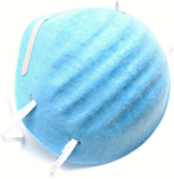
You may see staff wearing protective equipment.
(gowns, gloves, masks, goggles)

CLEAN

DIRTY

Please no paper charts/forms in this room!

MASKED PATIENTS



ONLY!

MASKS AND GARBAGE

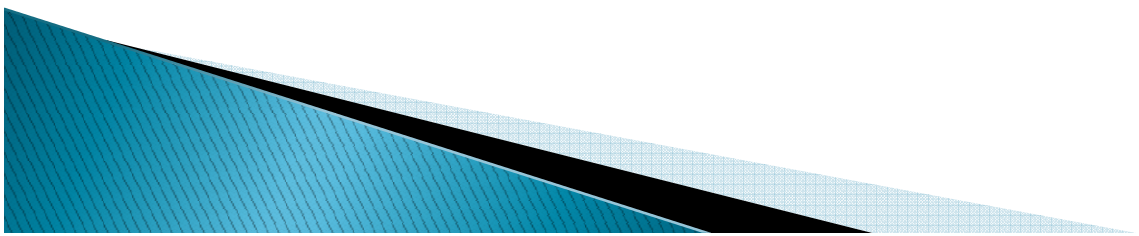
ONLY!

Isolation Patients Only!

Hot Zone

Wins and losses

- Well
  - Advance preparation really paid off, especially in the early days
  - Control and consistency of messaging bred confidence in staff and patients
  - Patient segregation/routing
- Not so well
  - Triage difficulties
  - Physician buy in/adherence to public health guidance



Pediatric Surge and Hospital Readiness

Michael R Anderson MD FAAP

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Vice Chair, National Commission on Children and Disasters
Washington DC

Vice President and Associate Chief Medical Officer, University Hospitals,
Cleveland OH

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Disclaimers

- Financial: None
- Professional: NDMS Part Time Federal Employee
- Off Label Use: None

Pediatric Surge

1. Issues Surrounding “Day to Day” Readiness

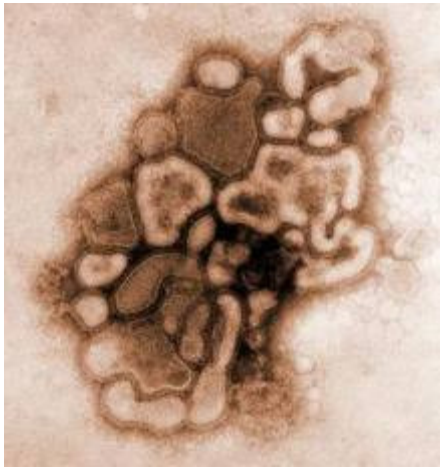
2. Elements of Preparation and Response to Pediatric Mass Events

3. Potential Solutions

4. CDC Guidance

5. Q and A

Pandemic and Surge



But are we ready for the disaster of ONE?

Take Home Point One:

- Day to day readiness for pediatric emergencies will help prepare for BIG events
  - Training
  - Equipment
  - Transfer Protocols
  - Transport
  - Drills
  - Regionalization

Take Home Point 2: Children are NOT Small Adults…

- Larger head for BSA → Head Injuries
- Higher Center of Gravity → Falls
- Large Area for Evaporative Losses → Temp Control
- Veins!!! → Access Nightmares
- Weight: Largest Change in over shortest time period → Larger Room for Errors

Pediatric Differences

- Vitals differ w age
  - Cheat Sheet
  - Practice/Experience
- Different Response to stress
- Different Diseases
- Triage Tools

Pediatric Physiology-Disasters

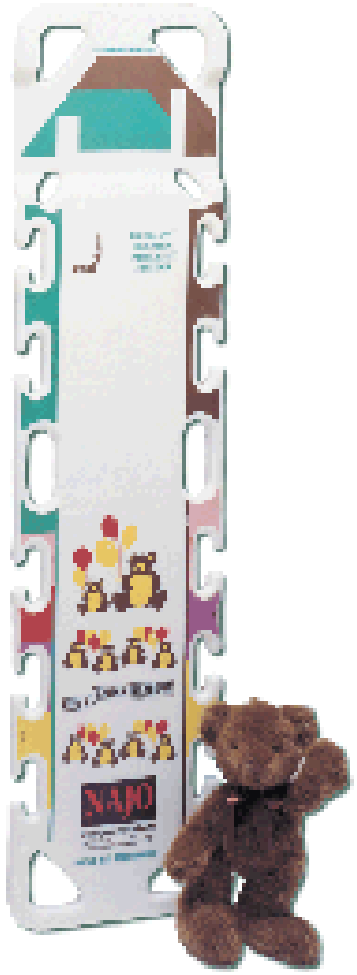
- Thin skin
- Greater surface area
- Closer to ground
- Faster Respiratory Rate
- Unable to escape
- Found in large groups

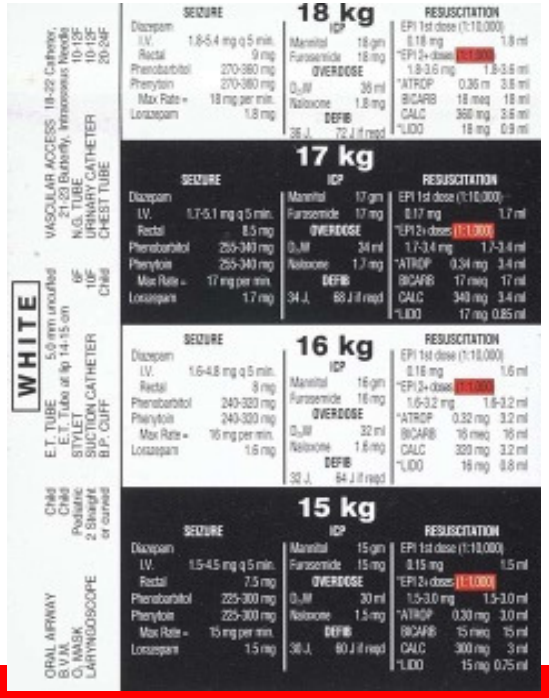
Pediatric Physiology-WMD

- Infectious Diarrhea
  - Greater risk of dehydration
- Smallpox
  - Greater risk of vaccine complications
- Blister agents
  - Greater risk of skin loss
- Nerve agents
  - Seizures, pulmonary edema
- Radiation
  - Greater penetration

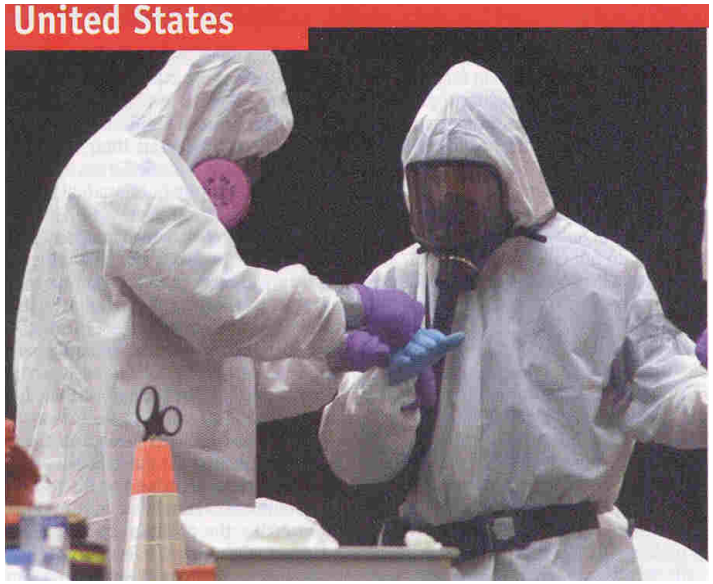
Pediatric Equipment

Pediatric Equipment





Pediatric Equipment: IV Access



How fast can these guys get an IV started in this 1 year old?

Continuum of Care

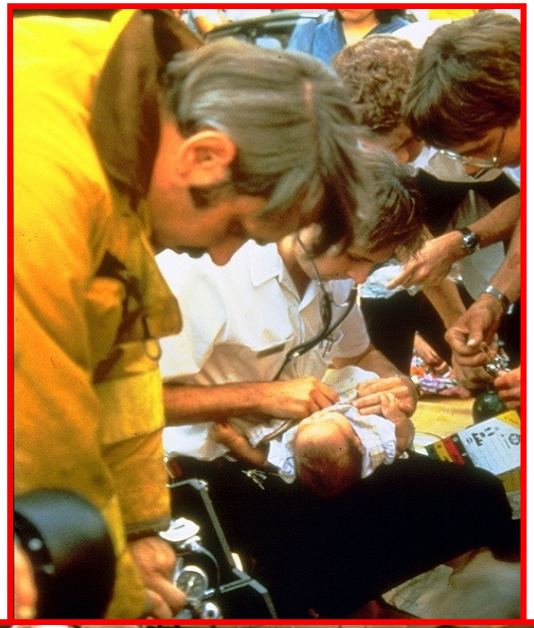
Take Home 3: We are NOT as prepared for day to day readiness as we should be……

So, How's The Foundation of Our Nation's Emergency Care System?

- Existing public safety systems (EMS, fire, etc) are over-taxed by day-to-day demands
- EMS and trauma systems are woefully under-funded
- Hospital-based ED's are dangerously overcrowded
- *Pediatric capabilities* of our emergency and disaster care systems is uncertain

Pediatric Emergency Experience Gap

- Children account for 5 to 10% of all EMS patients
  - Limited training in pediatric care
  - Limited experience for EMT's and paramedics with sick kids
- Children make 25-30 million ED visits per year
  - Nearly 90% of children are cared for in general hospital ED's
  - Many ED's care for few children
    - 50% of ED's see < 10 per day
  - Limited experience with sick kids for RNs and MDs in most US ED's



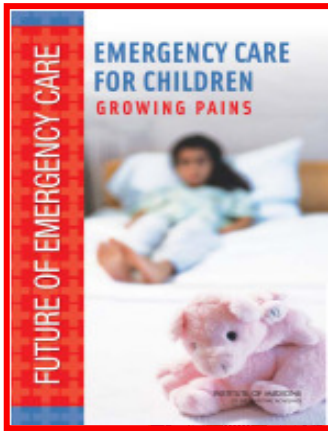
Gausche-Hill M, et al. Pediatrics 2007; 120:1229.

Pediatric Readiness: "Growing Pains"

- Although children make up at least 1/4 of all ED visits nationwide
  - Most general EDs and EMS agencies do not require specialized *pediatric training* for their clinical staff
  - Only 6% of all EDs have the full scope of pediatric equipment, medications, *supplies*
  - Paucity of *research* on best practices, clinical outcomes, & patient safety in pediatric emergency care

"If there is one word to describe the current state of pediatric emergency care in 2006, it is <u>UNEVEN</u>"

--- IOM Panel, 2006



Take Home 4: Surge!!

Resources:

- http://www.bt.cdc.gov/healthcare/pediatric.asp

- **COORDINATING PEDIATRIC MEDICAL CARE DURING AN INFLUENZA PANDEMIC**
- **PANDEMIC INFLUENZA PEDIATRIC OFFICE PLAN TEMPLATE (287 KB/32 PAGES) (WORD VERSION)**
- **OFFICE PREPAREDNESS FOR PEDIATRIC EMERGENCIES: PROVIDER MANUAL**
- **A DISASTER PREPAREDNESS PLAN FOR PEDIATRICIANS**
- **RESOURCE DIRECTORY TO ASSIST PEDIATRICIANS TO PREPARE THEMSELVES, THEIR HOSPITALS/OFFICES AND THEIR PATIENTS AND THEIR FAMILY**

Important Elements of Surge Planning…..

Children's Hospitals:

- Area 1 Pediatric Medical Liaisons Between Children's Hospitals and General Hospitals
- Area 2 Internal Surge Capacity Assessment
- Area 3 Pandemic influenza alternate staffing model
- Area 4 Coordination with the Community Pandemic Influenza Response
- Area 5 Patient- and Family-Centered Care During a Pandemic Influenza Surge
- Area 6 Pandemic Influenza Pediatric Triage

Important Elements of Surge Planning…..

- Local Hospitals and Emergency Departments:

- Area 1 Pediatric Medical Liaisons and Other Key Contacts
- Area 2 Internal Pediatric Care Capabilities Assessment
- Area 3 Coordination with the Community Pandemic Influenza Response
- Area 4 Patient- and Family-Centered Care During a Pandemic Influenza Surge
- Area 5 Pandemic Influenza Pediatric Triage

Important Elements of Surge Planning…..

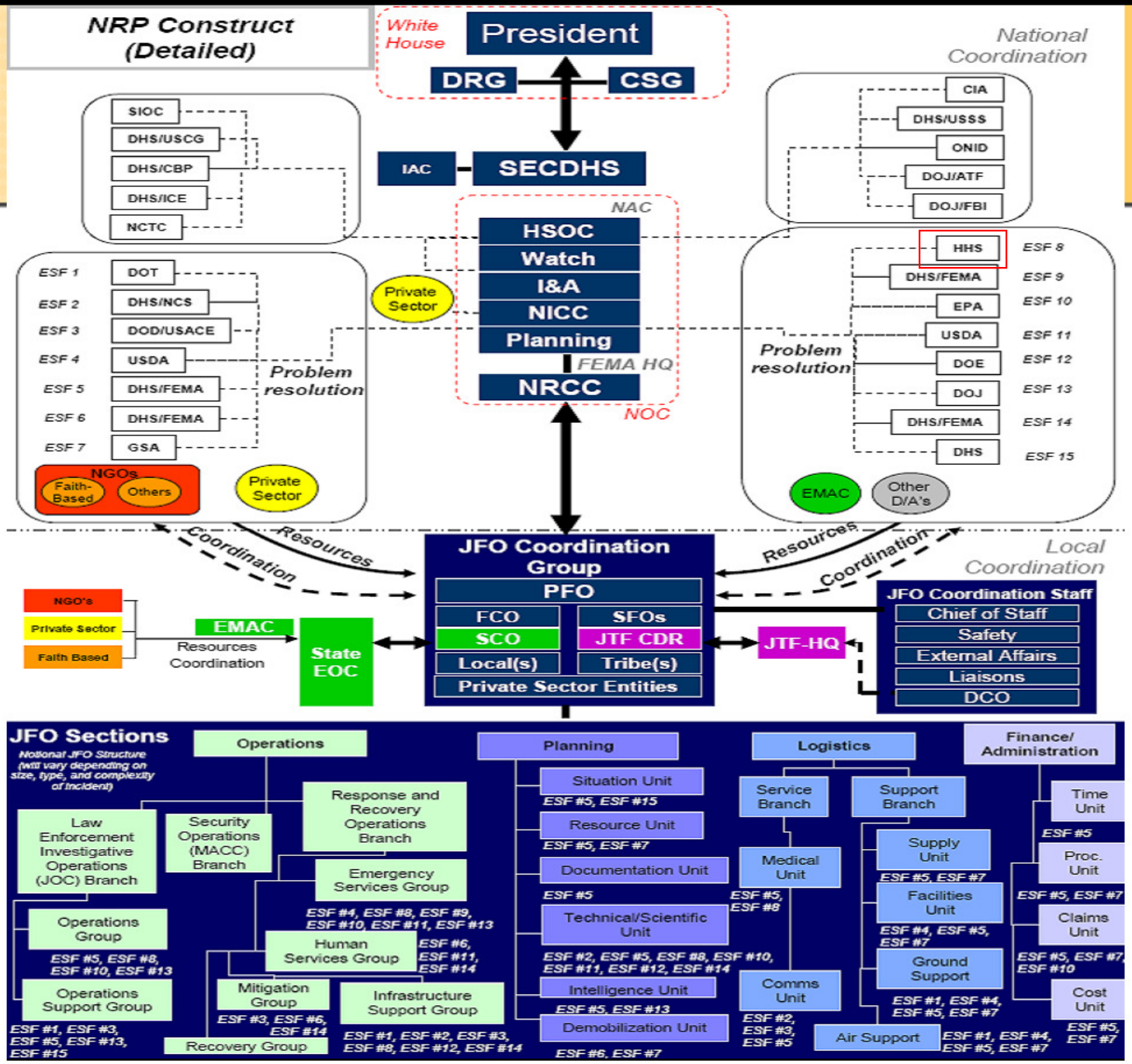
- <u>Local and Regional Planners:</u>

- Area 1 Include pediatric experts in planning

- Area 2: Don't simply lump children w special needs issues

- Area 3: Reach out to peds facilities and children's hospitals

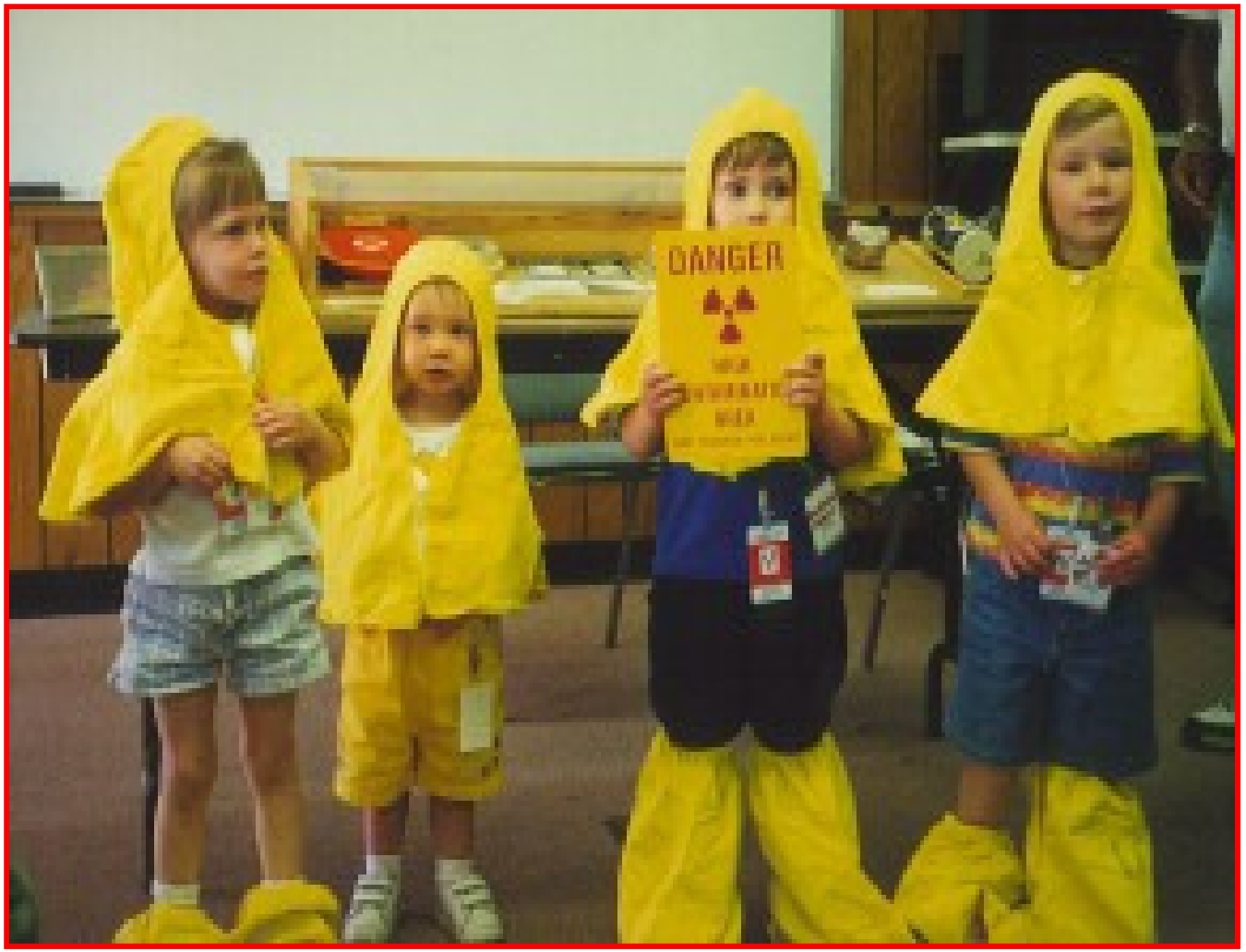
OPHEP


NRP Construct (Detailed)
White House
President
DRG
CSG
National Coordination
IAC
SECDHS
NAC
HSOC
Watch
I&A
NICC
Planning
FEMA HQ
NRCC
NOC
SIOC
DHS/USCG
DHS/CBP
DHS/ICE
NCTC
CIA
DHS/USSS
ONID
DOJ/ATF
DOJ/FBI
ESF 1 DOT
ESF 2 DHS/NCS
ESF 3 DOD/USACE
ESF 4 USDA
ESF 5 DHS/FEMA
ESF 6 DHS/FEMA
ESF 7 GSA
Problem resolution
NGOs
Faith-Based
Others
Private Sector
Private Sector
HHS ESF 8
DHS/FEMA ESF 9
EPA ESF 10
USDA ESF 11
DOE ESF 12
DOJ ESF 13
DHS/FEMA ESF 14
DHS ESF 15
Problem resolution
EMAC
Other D/A's
Coordination
Resources
Resources
Coordination
Local Coordination
JFO Coordination Group
PFO
FCO
SCO
Local(s)
SFOs
JTF CDR
Tribe(s)
Private Sector Entities
JFO Coordination Staff
Chief of Staff
Safety
External Affairs
Liaisons
DCO
NGO's
Private Sector
Faith Based
EMAC
Resources Coordination
State EOC
JTF-HQ
JFO Sections
Notional JFO Structure (will vary depending on size, type, and complexity of incident)
Operations
Law Enforcement Investigative Operations (JOC) Branch
Security Operations (MACC) Branch
Response and Recovery Operations Branch
Emergency Services Group
ESF #4, ESF #8, ESF #9, ESF #10, ESF #11, ESF #13
Human Services Group
ESF #6, ESF #11, ESF #14
Operations Group
ESF #5, ESF #8, ESF #10, ESF #13
Operations Support Group
ESF #1, ESF #3, ESF #5, ESF #13, ESF #15
Mitigation Group
ESF #3, ESF #6, ESF #14
Recovery Group
Infrastructure Support Group
ESF #1, ESF #2, ESF #3, ESF #8, ESF #12, ESF #14
Planning
Situation Unit
ESF #5, ESF #15
Resource Unit
ESF #5, ESF #7
Documentation Unit
ESF #5
Technical/Scientific Unit
ESF #2, ESF #5, ESF #8, ESF #10, ESF #11, ESF #12, ESF #14
Intelligence Unit
ESF #5, ESF #13
Demobilization Unit
ESF #6, ESF #7
Logistics
Service Branch
Medical Unit
ESF #5, ESF #8
Comms Unit
ESF #2, ESF #3, ESF #5
Support Branch
Supply Unit
ESF #5, ESF #7
Facilities Unit
ESF #4, ESF #5, ESF #7
Ground Support
ESF #1, ESF #4, ESF #5, ESF #7
Air Support
ESF #1, ESF #4, ESF #5, ESF #7
Finance/ Administration
Time Unit
ESF #5
Proc. Unit
ESF #5, ESF #7
Claims Unit
ESF #5, ESF #7, ESF #10
Cost Unit
ESF #5, ESF #7

Conclusions

- Children:
  - 22% of the population
  - Unique physiology
  - Under-represented in disaster planning
  - Urgent need for local/regional/national planning
  - Good disaster response begins with good day to day response
  - Kids issues need a VOICE

Thank You For Your Commitment to our Nation's Children !



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Thank you for joining!
Please email us questions at coca@cdc.gov